VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MI/IDD/Related Conditions SUPPLEMENT: LEVEL II

Name: _____ Recommendation for Services _____

B. This section is to be completed by the contractor for the Level II evaluation process.

1. EVALUATIONS REQUIRED UPON RECEIPT OF REFERRAL (Check evaluations submitted upon receipt of referral)

_____ Neurological Evaluation
_____ Psychological Assessment
_____ Psychiatric Assessment
_____ Psychosocial/Functional Assessment
_____ History and Physical Examination
_____ Other (please specify)_____

2. RECOMMENDATION

_____ Specialized services are not indicated.

_____ Specialized services are indicated.

Comments:_____

_____

_____

_____

3 .Date referral package received: _____ Date package sent to DBHDS: _____

QMHP Signature (MI diagnosis) **Date** Telephone Number

Psychologist Signature (IDD diagnosis) **Date** Telephone Number

Case Manager Signature/Title **Date** Telephone Number

Agency / Facility Name Agency / Facility Name ID # (if applicable)

Mailing Address

C. THIS SECTION IS TO BE COMPLETED ONLY BY THE DEPARTMENT OF BEHAVORIAL HEALTH AND DEVELOPMENTAL SERVICES**.**

Date referral package received:_____ Concur with recommendations of specialized services**? ____ yes ____ no**

Comments:

_____

_____

_____

Copies of referral package sent to:	**Representatives Name**	**Date Package Sent**
___ PAS representative		
___ Community Services Board		
___ Admitting/retaining nursing facility		
___ Discharging hospital **(if** applicable)		
____ Individual being evaluated		
___ Individual's family		
___ Individual's legal representative **(if** any)		
___ Attending physician		

Appeals information included.

Signature of State MH/MRA Title Date Telephone Number